Gerontological Nursing

Nursing Care
In
Physiological Disorders

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Self-Care Approach to Gerontological Nursing Process

Self-Responsibility

Self-Regulation

Self-Management

*Who has thought of her/his own **AGING**?*

Quality of Life

The Health Continuum

BOX 1-1 Myths of Aging

- Myth: Being old means being sick.
  - Fact: Fewer than 5% of people over the age of 65 are frail enough to require care in a skilled nursing facility.
  - Fact: Many older adults have chronic diseases but still function quite well.
- Myth: Most older people are set in their ways and cannot learn new things or take up new activities.
  - Fact: Older people can learn new things and should be challenged to stay mentally active.
  - Fact: Healthy older adults find hobbies that they can enjoy to give life meaning and pleasure.
- Myth: Health promotion is wasted on older people.
  - Fact: It is never too late to begin good lifestyle habits such as eating a healthy diet and engaging in exercise.
  - Fact: Although it may not be possible to reverse all of the damage caused by bad habits, it is never too late to stop smoking cigarettes or drinking too much alcohol. Even people who quit smoking at older ages enjoy better health outcomes than those who continue to smoke.
- Myth: Older adults do not pull their own weight and are a drain on societal resources.
  - Fact: Older people contribute greatly to society by supporting the arts, doing volunteer work, and helping with grandchildren.
  - Fact: Paid employment is not the only measure of value and productivity and older people continue to make contributions to society into advanced old age and many continue working, volunteering, and mentoring others long after formal retirement.
- Myth: Older people are isolated and lonely.
  - Fact: Many older people join clubs and do volunteer work to stay active and connected.
  - Fact: There are many ways to maintain contact with people and healthy older adults have a variety of great options for staying connected with others.
- Myth: Older people have no interest in sex.
  - Fact: Although sexual activity does decrease in some older people, there are tremendous differences. Most often, the human need for affection and physical contact continues throughout life.

Source: Adapted from Saison, Smith, Segal, & White, 2010.

BOX 1-2

Benefits of Healthy Aging

- Creativity and confidence are enhanced.
- Coping ability increases.
- Gratitude and appreciation deepen.
- Confidence increases with less reliance on the approval of others.
- Self-understanding and acceptance increase.

BOX 1-5 Opportunities to Improve Older Americans' Health and Quality of Life

Poor health and loss of independence are ***not*** inevitable consequences of aging. The following strategies have proven effective in promoting the health of older adults:

- **Healthy lifestyles.** Research has shown that healthy lifestyles are more influential than genetic factors in helping older people avoid the deterioration traditionally associated with aging. People who are physically active, eat a healthy diet, do not use tobacco, and practice other healthy behaviors reduce their risk for chronic diseases and have half the rate of disability of those who do not lead healthy lifestyles.
- **Early detection of diseases.** Screening to detect chronic diseases early in their course, when they are most treatable, can save many lives; however, many older adults have not had recommended screenings. For example, 60% of Americans over age 65 have not had a sigmoidoscopy or colonoscopy in the previous 5 years to screen for colorectal cancer, even though Medicare covers the cost.
- **Immunizations.** More than 40,000 people age 65 or older die each year of influenza and invasive pneumococcal disease. Immunizations reduce a person's risk for hospitalization and death from these diseases. Yet in 2010, 34% of Americans age 65 or older had not had a recent flu shot, and 37% had never received a pneumonia vaccine.
- **Injury prevention.** Falls are the most common cause of injuries to older adults. More than one third of adults age 65 or older fall each year. Of those who fall, 20% to 30% suffer moderate to severe injuries that decrease mobility and independence. Removing tripping hazards in the home and installing grab bars are simple measures that can greatly reduce older Americans' risk for falls and fractures.
- **Self-management techniques.** Programs to teach older Americans self-management techniques can reduce the pain and costs of chronic disease. For example, the Arthritis Self-Help Course, disseminated by the Arthritis Foundation, has been shown to reduce arthritis pain by 20% and visits to physicians by 40%. Unfortunately, less than 1% of Americans with arthritis participate in such programs, and courses are not available in many areas.

Source: Centers for Disease Control and Prevention. (2011b). *Chronic disease prevention. Healthy aging: Helping people to live long and productive lives and enjoy a good quality of life.* Retrieved from http://www.cdc.gov/chronicdisease/resources/publications/AAG/aging.htm


Assessment
Diagnosis
Outcome Identification
Planning
Implementation
Evaluation
Nursing Process

BOX 2-2

Examples and Application of the ANA Standards of Clinical Gerontological Nursing Care

Standard I: Assessment

A systematic and complete assessment that is culturally appropriate is the basis for development of the nursing care plan. Many common problems affecting the older adult begin with vague signs and symptoms. In order to adequately treat the problem, a careful assessment is needed.

Standard II: Diagnosis

Organizing the assessment information independently or with other members of the interprofessional team into medical and nursing diagnoses helps form the basis for care interventions.

Standard III: Outcome Identification

NOC

Identifying and setting mutually agreed upon goals or outcomes with the older person's and family's input can help with resource allocation and indicate which members of the interprofessional team are needed to improve health and functional status.

Standard IV: Planning

The plan establishes the interventions needed to achieve the stated outcomes.

Standard V: Implementation

NIC

The gerontological nurse along with others on the interprofessional team implements the plan and notes the response to the various interventions. Evidence-based nursing interventions might be direct (direct provision of nursing care) or indirect (e.g., advocacy, sharing information with others on the team, referral to ethics committees). Input from the older person and family is crucial during the implementation process.

Standard VI: Evaluation

The older adult's response to the plan is noted and used to evaluate the effectiveness of nursing care. Progress towards the identified outcomes may be satisfactory or it may be necessary to modify the plan and begin the process again by collecting new data, revising the nursing diagnoses and modifying the plan of care.

BOX 2-4 Barriers That Can Disrupt the Communication Process

1. Fear of one's own aging
2. Fear of showing emotion or being around emotional patients
3. Fear of missing something and feeling the need to write down every detail of the encounter
4. Fear of being called on to rectify every problem verbalized by the patient
5. Lack of knowledge of the patient's culture, goals, and values
6. Unresolved issues with aging relatives in the nurse's own family that can lead to insensitivity
7. Feeling that professional distance must be maintained at all cost
8. Being overworked, or overscheduled, and lacking proper time to communicate with older patients

BOX 3-2 Potential Difficulties in Obtaining Health Histories

- **Communication difficulties.** Decreased hearing or vision, slow speech, and use of English as a second language have an effect on communication.
- **Underreporting of symptoms.** Fear of being labeled as a complainer, fear of institutionalization, and fear of serious illness can influence symptom reporting.
- **Vague or nonspecific complaints.** These may be associated with cognitive impairment, drug or alcohol use or abuse, or atypical presentation of disease.
- **Multiple complaints.** Associated "masked" depression, presence of multiple chronic illnesses, and social isolation are often an older person's cry for help.
- **Lack of time.** New patients scheduled for geriatric assessment should have the minimum of a 1-hour appointment with the gerontological nurse. Shorter appointments will result in a hurried interview with missed information.

Source: Kane et al., 2009.

Assessment

An example model for assessment

TABLE 2-2 Gordon's Functional Health Patterns

Functional Health Pattern	Behavioral Area
Health perception–health management	The older individual's perceived health and well-being along with self-management strategies
Nutritional–metabolic	Patterns of food and fluid consumption relative to metabolic need and nutrient supply
Elimination	Patterns of excretory function and elimination of waste (e.g., bowel, bladder)
Activity–exercise	Patterns of exercise and daily activity. Includes leisure and recreation
Sleep–rest	Patterns of sleep, rest, and relaxation
Cognitive–perceptual	Patterns of thinking and ways of perceiving the world and current events
Self-perception–self-concept	Patterns of viewing and valuing self (body image and psychological state, self-image, etc.)
Roles–relationships	Patterns of engagement with others, ability to form and maintain meaningful relationships, assumed roles
Sexuality–reproductive	Patterns of sexuality and satisfaction with present level of interaction with sexual partners
Coping–stress tolerance	Patterns of coping with stressful events and level of effectiveness of coping strategies
Values–beliefs	Patterns of beliefs, values, and perception of the meaning of life that guide choices or decisions

Source: Adapted from Gordon, 1994. *Nursing diagnosis: Process and application*. St. Louis, MO: Mosby.

Gordon's Functional Health Patterns:

- ***Health Perception-Health Management*** *(Current health, symptoms analysis, ROS)*
- ***Nutritional-Metabolic*** *(GI,Integumentry,Endocrine systems)*
- ***Elimination*** *(GI and Urinary systems)*
- ***Activity-Exercise*** *(Cardiovascular,Respiratory,Musculoskeletal systems)*
- ***Cognitive-Perceptual*** *(Nervous system,Mental status,Senses,Pain)*
- ***Sexuality-reproductive*** *(Genitourinary system,Breat examination)*
- ***Sleep-Rest***
- ***Self Perception-Self Concept***
- ***Roles-Relationships***
- ***Coping-Stress tolerance***
- ***Values-Beliefs***

Best Practices Instruments for Use With Older Adults

The Hartford Institute recommends the following instruments for use when assessing the function of older adults. These instruments have been used clinically for many years, are commonly referred to in practice, and have been validated on large patient groups. Additional assessment tools that focus on specific problems will be included in the appropriate chapters in this text. Recommended functional assessment tools include:

1. Katz Index of Independence in Activities of Daily Living (Katz, Down, Cash, et al., 1970).
2. PULSES Profile. Measures general functional performance in mobility and self-care, medical status, and psychosocial factors.
   P = physical condition
   U = upper limb function
   L = lower limb function
   S = sensory components
   E = excretory functions
   S = support factors (Granger, Albrecht, & Hamilton, 1979)
3. SPICES. An overall assessment tool used to plan, promote, and maintain optimal function in older adults.
   S = sleep disorders
   P = problems with eating and feeding
   I = incontinence
   C = confusion
   E = evidence of falls
   S = skin breakdown

Source: Hartford Institute for Geriatric Nursing, 2011a.


Diagnosis

BOX 3-1 Reasons for Interdisciplinary Collaboration to Improve Care

- Older adults may face a multitude of complex problems requiring assessment and intervention from various healthcare professionals.
- Assembling a group of knowledgeable providers can enhance problem solving and the delivery of health care.
- Coordination of services can be enhanced by various professionals working together.
- The patient will have access to a comprehensive and integrated care plan.
- Care can be safer for patients, more cost effective, and efficient.
- Healthcare professionals can feel supported and encouraged by the input and collaboration from other professionals. Interdisciplinary care has the potential to decrease feelings of "burnout" when caring for older patients with complex health needs.

Source: Hartford Institute for Geriatric Nursing, 2011b.

BOX 2-3 Ethical Principles

- **Beneficence/nonmaleficence.** To do good and not harm patients.
- **Justice.** To be fair and distribute scarce resources equally to all in need.
- **Autonomy.** To respect patients' needs for self-determination, freedom, and patient rights.

Nursing Outcomes Classification (NOC)

Planning

Nursing Interventions classification (NIC)

BOX 3-3 Nursing Interventions for Altered Health Maintenance Goals

1. Lifestyle changes
2. Acquisition of new health-promoting thought patterns and behaviors
3. Self-care in managing chronic health conditions or risks

Source: Scherb et al., 2011.

Nursing Actions Based on Knowledge & Skills

(ANA,2010)

1) *Inform and assist clients(adequate time & information)*
2) *Evidence-Based practice*
3) *Collaborate with inter-professional team members*
4) *Advocate for older patients and their family*
5) *Ethical practice*
6) *Complete & holistic patient assessment*
7) *Differentiate normal changes of aging and disease-related symptoms*
8) *Utilize therapeutic relationship*
9) *Provide support to caregivers/family members*
10) *Educate older adults and family members about healthy behaviors, care and monitoring chronic illness*
11) *Engage in lifelong learning continued professional development*
12) *Serve as a role model for other caregivers by advocating for the autonomy of the older adults*

Holistic & Dignified CARE

BOX 3-5 Documentation Guidelines

- Write clearly and legibly so others can read the record without struggling or ambiguity.
- Record all significant nursing interventions and patient responses.
- Record all significant nursing interventions withheld or deferred (e.g., "laxative not given as patient has diarrhea").
- Record any unusual event or circumstances (falls, patient or family comments, concerns).
- Record routine and ongoing nursing care.
- Record conversations and phone calls to physicians, advanced practice nurses, families, diagnostic facilities, and so on.
- Record recommended actions or inactions ("no new orders received") in response to phone calls and inquiries.
- When taking verbal medication orders by phone, request the physician repeat doses at least twice to verify accuracy. For example, "Dr. Jones, I would like to confirm that you ordered Compazine, 25 milligrams, be given orally every 6 hours for complaint of nausea. Is that correct?"

BOX 3-5 Documentation Guidelines

- Ask the physician or advanced practice nurse to fax the information conveyed in the telephone order if possible, as an additional safeguard.
- Record thoughts when any actions are taken or not taken as the result of nursing judgments. For example, "Oral fluids withheld as patient lacks gag reflex and is at risk for aspiration. Dr. Jones notified by phone and IV fluid rate increased by 50 mL/hr to prevent dehydration."
- Do not scratch out, white out, enter notes later, or obliterate any part of the patient record. If an error is made, draw a single line through the entry and write "mistaken entry" (or, e.g., "incorrect patient") and sign your name.

TABLE 3-3 Recommended Health Screenings and Interventions for Older Persons

Screening/Intervention	Recommended Interval
For Primary Prevention	
Bone mineral density (women)	At least once after the age of 65
Blood pressure	Yearly
Diabetes screening	Every 3 years in people with BP > 135/80
Herpes zoster immunization	Once after the age of 60
Influenza immunization	Yearly
Lipid disorder screening	Every 5 years, more often in older people with coronary artery disease, diabetes, peripheral artery disease or history of prior stroke
Obesity (height and weight)	Yearly
Pneumonia immunization	Usually once. Revaccination for healthy persons is not recommended. However, if a patient received the first dose prior to age 65, give a single revaccination at age 65 (or older) if at least 5 years have elapsed since the previous dose.
Smoking cessation	Every health encounter
Tetanus booster	Every 10 years. Verify that the primary series was received.

CDC,2011

TABLE 3-3 Recommended Health Screenings and Interventions for Older Persons

Screening/Intervention	Recommended Interval
For Secondary Prevention	
Abdominal aortic aneurysm	Once between ages 65–75 in men who are smokers or have a history of smoking
Alcohol abuse	Periodically
Depression screening	Yearly
Sigmoidoscopy/colonoscopy	Every 10 years from ages 50–75
Fecal occult blood	Yearly
Mammography/clinical breast exam	Every 2 years in women ages 50–74
Hearing/vision screening	Yearly
Pap smears	Limited benefit in women over the age of 65 or those without a cervix after hysterectomy.

Sources: Centers for Disease Control and Prevention (2011); U.S. Preventive Services Task Force (2011).